Report on an unannounced inspection of

HMP Lowdham Grange

by HM Chief Inspector of Prisons

15–26 May 2023

Contents

Introduction

HMP Lowdham Grange, near Nottingham, is a category B training prison holding up to 800 adult men, many convicted of very serious offences. A privately-run establishment, the prison first opened in 1998 and was operated by Serco for 25 years. Following a competition and market test, the prison was handed over to Sodexo on 16 February 2023. During this inspection the prison was in a state of active transition with the new provider seeking to make progress toward implementation of their contract and delivery model. This was the first time that management of a prison had been handed from one private provider to another.

We found an atmosphere of uncertainty and anxiety, with staff and prisoners keen to tell us about their concerns as well as expressing general dissatisfaction about how they were being treated. These findings were reflected in our healthy prison test scores, with outcomes judged not sufficiently good in three tests and poor in our test of purposeful activity, a significant deterioration from our previous inspection in 2018. Leaders were grappling with many issues, including the loss of some key and specialist staff, a lack of understanding of new routines and expectations, and a widespread perception among prisoners and staff of poor communication. Appointed at relatively short notice, and in response to the departure of others, the new director was very experienced and appeared to have a good understanding of the extent of the challenge. He expressed to us his commitment to see the delivery of the new contract to a successful conclusion.

The prison was not safe enough, and the sense of instability was reflected in the availability of drugs and levels of recorded violence, which were lower than in 2018 but had increased in recent months and remained high in comparison with similar prisons. Initiatives to promote positive behaviour, as well as oversight and assurance of the use of force and segregation, were not yet good enough. The poor state of governance was perhaps most starkly reflected in a failure to investigate consistently allegations of misconduct among staff. Our staff survey showed discontent among some staff groups, low morale, and a mistrust of the new leadership. Of greatest concern, however, were the 14 prisoner deaths, including six which were self-inflicted, that had occurred since we last inspected. Three of these had taken place in March, shortly after the transition, prompting speculation among staff and prisoners alike that uncertainty and change were causal factors. The evidence pointed to continuing high levels of self-harm and an indifferent approach to oversight and intervention.

The number of prisoners who told us they felt respected by staff was consistent with findings from the previous inspection and similar prisons, although many staff were inexperienced and seemed to us to be in need of guidance, support and leadership. Prisoners expressed frustration that their basic requests were not dealt with, and staff needed to embrace change and apply themselves more constructively, but peer support, reasonable access to services and good environmental and living conditions helped to mitigate this. Work to promote equality had largely lapsed since the transition, but there was little evidence of

unfair treatment of prisoners with protected characteristics. In contrast, outcomes in health care were undermined by significant staff shortages and inadequate oversight.

The prison was failing to fulfil its rehabilitative function. Unlock was often sporadic, with staff and prisoners uncertain about routines. Our own spot checks indicated that more than 40% of prisoners were locked up during the working day, with between three and nine hours out of cell for each individual, depending on their employment status. The frustration this created among prisoners was palpable. Access to work and education was poor, with our Ofsted colleagues judging all aspects of provision as 'inadequate', their lowest assessment. Many prisoners posed a high risk of harm, but offender management, public protection and resettlement services all needed to be better and far less peripheral to the life of the prison and the experience of prisoners. The recruitment of two new senior probation officers was a start, but they needed support.

Lowdham Grange was struggling. To some extent this was predictable in the context of transition from one provider to another. Leaders were, however, sighted on the issues and the full delivery of the new contract should address many of the concerns we have identified. They need support and encouragement to make sure this is achieved expeditiously.

Charlie Taylor
HM Chief Inspector of Prisons
July 2023

What needs to improve at HMP Lowdham Grange

During this inspection we identified 13 key concerns, of which six should be treated as priorities. Priority concerns are those that are most important to improving outcomes for prisoners. They require immediate attention by leaders and managers.

Leaders should make sure that all concerns identified here are addressed and that progress is tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

Priority concerns

1. **The prison was not safe enough.** Outcomes were being undermined by violence, the ready availability of illegal drugs and an inexperienced staff group who lacked the confidence to provide effective supervision and management.

2. **The level of self-harm was high and had risen in recent months.** Not enough was being done to support prisoners in crisis and those at risk of self-harm.

3. **Longstanding staff shortages in health care resulted in lengthy waits for services and some poor outcomes for patients.** This was exacerbated by limited strategic support and a lack of governance over the service.

4. **There were not enough places in education, skills and work for the population.** Allocations took too long and were not informed by prisoners' career goals.

5. **There were not enough opportunities for prisoners to complete offending behaviour work and other programmes aimed at reducing their risks.**

6. **Public protection processes were not robust.** Too few prisoners had been assessed for their suitability to have contact with children. Managers did not have a comprehensive understanding of all emerging risks and could not therefore manage them effectively. Public protection and pre-release arrangements were not good enough.

Key concerns

7. **There was insufficient oversight and accountability for custody officers, particularly in their use of force.** The pervading culture among officers was not focused on responding to prisoner need and the delivery of effective support. Managers did not provide robust oversight to hold officers to account and we were, for example, told about very poor behaviour by some staff working in the segregation unit. Leaders had also failed to investigate serious concerns about the use of force against some prisoners.

8. **Too many prisoners were segregated for long periods without access to a decent and meaningful regime and there were no clear reintegration plans.**

9. **Arrangements to meet the needs of prisoners with protected characteristics were weak.**

10. **Partnership working between the health care provider and the prison was poor.** The clinical judgment of health care staff was sometimes ignored; this included a lack of investigation into several serious safeguarding concerns they had raised.

11. **The education, skills and work curriculum was too narrow and lacked ambition.** There was no reading strategy. Most accredited programmes were only available at level 1 and below. In work, prisoners could not acquire accredited qualifications.

12. **Leaders did not make sure that prisoners with additional learning needs had the support they needed.** In nearly all cases that identified an additional learning need, further detailed assessments had not taken place.

13. **The number of prisoners being released was increasing, but the prison had no dedicated resettlement staff or provision for housing support.**

14. **The applications and complaints systems were not fully effective and consultation with prisoners led to relatively few changes in practice.**

Care Quality Commission regulatory action

The Care Quality Commission took enforcement action in the form a warning notice, served to the provider on 08/06/2023 under Section 29A of the Health and Social Care Act 2008. The regulatory breaches will be followed up with the health care provider.

About HMP Lowdham Grange

Task of the prison/establishment
A men's category B training prison

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 892
Baseline certified normal capacity: 894
In-use certified normal capacity: 892
Operational capacity: 908

Population of the prison
- 97% of the population were serving long sentences of more than four years, about a third of whom were serving indeterminate sentences.
- 11% of prisoners were foreign nationals.
- 40% of prisoners were from a minority ethnic background.
- 68% of prisoners were under 40 years old.

Prison status and key providers
Private: Sodexo Justice

Physical and mental health and substance misuse treatment providers:
Nottinghamshire Healthcare NHS Foundation Trust
Dental health provider: Time for Teeth
Prison education framework provider: Novus
Escort contractor: Serco

Prison department
Privately managed prisons

Prison Group Director
Neil Richards

Brief history
HMP Lowdham Grange in Nottinghamshire holds over 800 prisoners, mainly serving long sentences. It has operated under a private finance initiative contract since it opened in 1998. The contract was initially held by Serco Justice and Immigration, part of Serco Plc. On 16 February 2023, Sodexo Justice Services became the new contract delivery company.

Short description of residential units
There were five house blocks comprising 14 residential wings – four each on house blocks 1 and 2 and two each on house blocks 3, 4 and 5.
The segregation unit had capacity for 25.

Name of director and date in post
Damian Evans, 18 April 2023

Changes of director since the last inspection
Martin Booth, 16 February 2023 – 17 April 2023

John Hewitson, October 2022 – February 2023
Martin Booth, February 2022 – October 2022
Mark Hanson, November 2018 – February 2022

Independent Monitoring Board chair
Barbara Morgan

Date of last inspection
13, 14, 20–24 August 2018

Section 1 Summary of key findings

Outcomes for prisoners

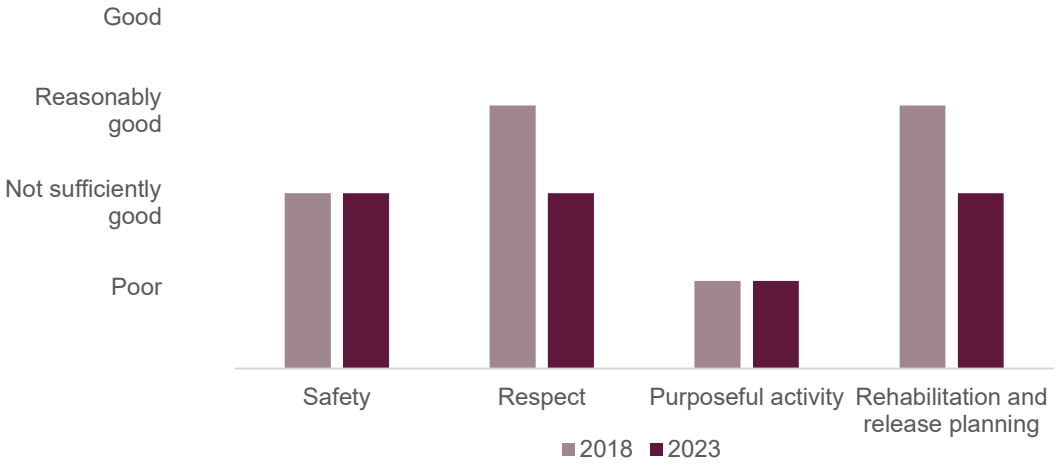
1.1 We assess outcomes for prisoners against four healthy prison tests: safety, respect, purposeful activity, and rehabilitation and release planning (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.2 At this inspection of HMP Lowdham Grange, we found that outcomes for prisoners were:

- not sufficiently good for safety
- not sufficiently good for respect
- poor for purposeful activity
- not sufficiently good for rehabilitation and release planning.

1.3 We last inspected HMP Lowdham Grange in 2018. Figure 1 shows how outcomes for prisoners have changed since the last inspection.

Figure 1: HMP Lowdham Grange prisoner outcomes by healthy prison area, 2018 and 2023



Progress on key concerns and recommendations from the full inspection.

1.4 At our last inspection in 2018 we made 72 recommendations, six of which were about areas of key concern. The prison fully accepted 66 of the recommendations and partially (or subject to resources) accepted five. It rejected one recommendation.

1.5 At this inspection we found that one of our recommendations about areas of key concern had been achieved and five had not been achieved. One recommendation made in the area of safety had been achieved, the other two had not been achieved. None of the single

recommendations made in respect, purposeful activity or rehabilitation and release planning had been achieved. For a full list of the progress against the recommendations, please see Section 7.

Progress on recommendations from the scrutiny visit

1.6 In January 2021 during the COVID-19 pandemic, we conducted a scrutiny visit at the prison. Scrutiny visits (SVs) focused on individual establishments and how they were recovering from the challenges of the COVID-19 pandemic. They were shorter than full inspections and looked at key areas based on our existing human rights-based *Expectations*. For more information on SVs, visit https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/scrutiny-visits/.

1.7 At the SV we made 11 recommendations about areas of key concern. At this inspection we found that one recommendation had been achieved and 10 had not been achieved.

Notable positive practice

1.8 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

1.9 Inspectors found three examples of notable positive practice during this inspection.

1.10 The prisoner advice line continued to provide men with valuable support. It was easily accessible via in-cell telephones and was well used. The calls were answered by prisoner peer workers who were able to provide immediate advice, guidance and support to those who called. Help was wide ranging, from questions about the regime to resettlement help. (See paragraph 4.4.)

1.11 The Veteran Care Through Custody programme helped prisoners who had served in the armed forces to manage their health and deal with trauma. (See paragraph 4.28.)

1.12 The recent initiative to phone all prisoners who were isolating in their cell to check if they needed any health input was positive and ensured their health needs were being met. (See paragraph 4.41.)

Section 2 Leadership

Leaders provide the direction, encouragement and resources to enable good outcomes for prisoners. (For definition of leaders, see Glossary.)

2.1 Good leadership helps to drive improvement and should result in better outcomes for prisoners. This narrative is based on our assessment of the quality of leadership with evidence drawn from sources including the self-assessment report, discussions with stakeholders, and observations made during the inspection. It does not result in a score.

2.2 HMP Lowdham Grange had been managed by Serco since it opened 25 years ago. In 2022 the contract was re-tendered and HM Prison and Probation Service (HMPPS) awarded the new contact to Sodexo. This was the first time that the leadership of a prison had been transferred from one private provider to another. HMPPS had put in place a six-month preparation phase leading up to the handover to Sodexo, but despite this, progress had not always happened early or quickly enough. The impact of some of the challenges had been significantly underestimated. For example, the number of leaders and staff who had resigned after the contract change had been announced had been higher than expected. All of the qualified psychologists had left and vacancies in other key areas had affected delivery of the regime and some core functions, including work to promote safety and security.

2.3 The new director was experienced and had established a set of priorities to take the prison forward and mobilise the new contract, but continuous improvement action was hampered by a lack of data and other information. For example, the new leaders could not access all of the data on violence and self-harm that predated their arrival, which made it harder for them to understand the scale of the problems they faced.

2.4 Leaders and managers had inadequate oversight of wing staff to hold them to account, which had allowed poor and unacceptable behaviour to continue, including reports of excessive use of force. Leaders had not investigated some physical injuries that prisoners had sustained during the use of force. Some staff were anxious about the change in provider and many others felt demotivated and poorly supported. Few knew the director's priorities and, in our staff survey, half of those who replied did not agree with them. Communication with staff was limited, but the new director was aware of the need for much better engagement with the staff group and had just reinstated full staff briefings to start addressing this.

2.5 Staff attrition and sickness rates remained too high and had increased significantly following the announcement that the contract would no longer be with Serco. The new director had acted swiftly to fill vacancies but recruiting qualified psychologists was taking time. Recruitment to senior officer grades was underway; leaders expected

that shortly after our inspection officer vacancies would be filled and they would be able to reinstate full regime.

2.6 Progress against recommendations made at our last full inspection was very disappointing: 75% had not been achieved by the previous delivery company. They had allowed a very restricted regime to continue for far too long after the ending of COVID-19 restrictions, with prisoners still only let out in cohorts. The new director had acted quickly to implement a new regime that made better use of available resources, but this still left far too many prisoners with very little time out of their cell.

2.7 Partnerships were variable. The education contract was very new and had yet to deliver any significant improvement. Joint working between the prison and the health care department had become strained, exacerbated by the lack of a local health care delivery board since January 2023. There were not enough opportunities for prisoners to address their offending behaviour and to make progress, and the expertise of the probation team was not sufficiently valued or integrated across departments. Despite a significant increase in the number of men being released from the prison, there was no partnership in place to offer comprehensive resettlement help.

2.8 Leaders had not provided enough activity spaces for the population and needed to further develop the allocation process to make sure that prisoners moved swiftly into education or work. Leaders did not routinely consider prisoners' career aspirations and, as a result, too many were demotivated and on long waiting lists to attend activities that might not support them to achieve their goals.

2.9 Leaders did not pay sufficient attention to some areas of work. For example, the separation of public protection work from offender management meant there was limited input from specialist probation staff, and significant weaknesses in this work meant leaders could not be confident that all necessary safeguards were in place. The focus on equality and diversity was limited, and disproportionate outcomes had not been addressed, but a new manager had recently been appointed to drive the work forward.

2.10 Prisoners had very few incentives to behave well and leaders had not gained prisoners' confidence in a local model designed to reward good behaviour, nor had they provided enough oversight for the scheme. Prisoners did not receive enough incentives to take up full-time employment, as they were only paid part-time wages.

Section 3 Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

Expected outcomes: Prisoners transferring to and from the prison are safe and treated decently. On arrival prisoners are safe and treated with respect. Risks are identified and addressed at reception. Prisoners are supported on their first night. Induction is comprehensive.

3.1 In our survey, 86% of prisoners said they were treated well in reception, compared with 75% in other similar prisons and we saw staff put prisoners at ease. An induction peer worker helped new arrivals and explained what would happen during the first few days.

3.2 Following two recent apparently self-inflicted deaths of relatively new arrivals (see paragraph 3.33), the current leaders had begun to review and improve care during prisoners' early days. The reception process had been revised so that safer custody and early days staff saw all new prisoners as they arrived. Initial safety and vulnerability interviews were undertaken in private and prisoners had a health assessment.

3.3 Leaders had plans to improve the condition of the reception area but at the time of our inspection the area was very untidy and cluttered, as well as poorly laid out and badly organised. Holding rooms were very small and bare. The reception processes were delivered in a haphazard way, which led to delays in moving prisoners to the first night centre. While all new arrivals were offered the chance of declaring contraband before being screened with a body scanner, they could come into contact with those waiting to be screened, which presented obvious risks of contraband being passed between prisoners to get it into the jail.

Reception area

Reception holding room

3.4 All prisoners were given additional telephone credit, and subject to checks, could contact one person on their first night to inform them of their arrival. All new prisoners could order from the shop before leaving reception, which reduced the chances of them falling into debt. Prisoners arriving without any funds were given a £5 advance, which they would repay over the coming weeks.

3.5 The vast majority of prisoners (85%) said they felt safe on their first night, compared with 69% in other similar prisons. Additional safety checks were undertaken during prisoners' first 24 hours. First night cells were clean and well prepared. The induction wing was well maintained, and the environment was calm.

First night cell

3.6 In our survey, 94% of prisoners said they had undertaken an induction and 65% said it was useful, both of which were better than in similar prisons. Peer workers were an integral part of the induction programme which started the day after prisoners arrived and lasted two weeks, after which prisoners would move to other wings. However, some prisoners remained in the induction wing for far longer.

Managing behaviour

Expected outcomes: Prisoners live in a safe, well ordered and motivational environment where their positive behaviour is promoted and rewarded. Unacceptable conduct is dealt with in an objective, fair, proportionate and consistent manner.

Encouraging positive behaviour

3.7 In our survey, 22% of prisoners reported feeling unsafe at the time of the inspection, which was similar to other category B prisons and the last inspection.

3.8 Recorded rates of violence had declined by about 16% compared to the last inspection but were still high compared to similar prisons.

There had been 235 recorded incidents of violence in the year ending April 2023, about 70% of which were prisoner-on-prisoner assaults. Assaults on staff had halved since our last inspection. A fifth of all incidents of violence were assessed as serious, which was a much higher proportion than when we last inspected in 2018.

3.9 Stability in the prison was being undermined by the availability of illicit drugs and the lack of experienced officers to enforce rules and tackle antisocial behaviour. Since December 2022 the level of violence had begun to increase once again and there had been more frequent incidents of disruptive behaviour; for example, 26 fire-setting incidents in the last few months.

3.10 Not all violent incidents, were investigated and, when they were, some lacked sufficient enquiry into the reasons behind prisoners' behaviour. Despite this, leaders broadly understood the reasons for violence, which included the availability of drugs, associated debt and bullying, as well as gang-related violence. However, they had not yet developed a meaningful strategy or action plan to manage these risks.

3.11 Wages were low and given the lack of purposeful activity some prisoners found it difficult to stay out of debt, which was an increasing problem on most wings. This resulted in some spending long periods of time isolating in their cells. There was poor identification of prisoners in this position. During our inspection we met 12 who had been isolating for several months, but leaders were not aware of some of them, which meant they were unsighted on the potential scale of the problem. Isolating prisoners received a very poor regime – most did not get access to a shower or fresh air every day and some said that they did not always receive their evening meal as it was not taken to their cell. Leaders had not put in place safeguards to make sure they received decent treatment.

3.12 The hotline from prisoners' in-cell phones to the safer custody team was not answered promptly because staff were frequently deployed to other duties. This meant prisoners self-isolating, in crisis or under threat sometimes did not get the help they needed.

3.13 Challenge, support and intervention plans (CSIPs, see Glossary) were not being used effectively to manage perpetrators of bullying or violence or to support victims. There were 17 in place at the time of the inspection and we reviewed seven of them. Investigations were not always undertaken and wing staff rarely knew which prisoners had a CSIP. The quality of written plans was poor; they only contained superficial targets, for instance 'refrain from violence' rather than addressing the underlying causes of the prisoner's behaviour. Actions identified on plans were rarely delivered.

3.14 There were very few incentives to encourage prisoners to behave well and the prison did not have a longer-term strategy to develop any. The incentives scheme was not delivered well and was largely ineffective. Some prisoners said a number of staff wrote negative entries about them in their notes without explaining when and why they had done

this, which did not help them to understand how to change their behaviour and led to frustration.

Adjudications

3.15 The adjudications system was in disarray. There had been over 2,700 charges in the previous year, which was very high. About half, had been dismissed or had not proceeded because of administrative errors. Some of them related to serious incidents, such as fire setting, abusive language and assaults, which meant poor and disruptive behaviour went unchallenged. The adjudication standardisation meeting had failed to challenge or address these issues.

3.16 Prisoners could not always attend their hearings because of a lack of officers to escort them to the segregation unit, where they were held.

3.17 Over 200 charges had been referred to the police for possible investigation, where no outcome had been recorded. Some were over a year old.

Use of force

3.18 Improvements in the governance of the use of force found during our scrutiny visit in 2020 had not been maintained, and oversight was now very weak. The prison had only recently received enough body-worn video cameras, and in that context, officers had rarely used them.

3.19 Leaders could not be confident that all use of force was necessary or proportionate. There was a lack of scrutiny of written reports and camera footage. Only one scrutiny meeting had taken place in the previous three months. This was especially concerning because a number of prisoners described staff using excessive force, some of which had resulted in significant physical injuries. Health care staff had reported several instances of prisoners with serious injuries following the use of force by staff, but leaders had not investigated these to determine whether force had been excessive.

3.20 As at the last inspection, written reports about use of force often contained conflicting accounts and evidence. There were about 50 staff statements that had not completed, and some were months overdue.

3.21 Despite our concerns about the use of force, the number of recorded incidents in the previous year was lower than at our last inspection and some other category B prisons. Most force used (70%) was spontaneous and in response to prisoners refusing orders or to prevent violence. Rigid bar handcuffs had been used in about three quarters of all incidents, but they were usually justified as they helped staff de-escalate situations quickly and maintain safety when escorting prisoners.

3.22 Batons had been drawn five times and used once in the previous year. Staff accounts of this latter incident were inconsistent, and leaders had not scrutinised or investigated it, despite some camera footage being available.

Segregation

3.23 It was not possible to know how many prisoners had been segregated in the last year as the data had not been transferred from the previous contract delivery company. Nevertheless, it was evident that the unit was used frequently as it was often full. The average length of stay was about 27 days, but during our inspection, two prisoners had been segregated for over 100 days with little done to address their issues or reintegrate them back into the main population. Analysis of data at the quarterly review meetings led to few actions or improvements. Several prisoners we spoke to provided examples of staff behaving very aggressively in the segregation unit.

3.24 There was no reintegration planning or evidence of staff helping prisoners to address the underlying reasons for their segregation. Based on the limited data provided, about 40% of prisoners were transferred from the unit to other establishments without having their problems addressed.

3.25 The daily regime was poor with very little time out of cell. Prisoners, for example, received only 30 minutes exercise outside in bleak cages each day and could only shower every other day, although they could make applications via an electronic kiosk on the unit on a daily basis.

Segregation exercise yard

3.26 Prisoners were not allowed out of their cell at mealtimes as their food was taken to their cell, which was unnecessary in many cases. Cells were reasonably equipped and included in-cell phones and radios, but toilets and communal showers were grubby. There was little purposeful activity available.

3.27 The reasons for initial or continued segregation were not always evidenced in the paperwork. Reviews did not set meaningful targets to promote reintegration to the wings. In the last few months, about 40% of those who had been in the unit had also been under assessment, care in custody and teamwork (ACCT) case management as they were at risk of suicide or self-harm, but there was not always enough evidence to justify the use of segregation, or whether its continued use was the best option.

Security

Expected outcomes: Security and good order are maintained through an attention to physical and procedural matters, including effective security intelligence and positive staff-prisoner relationships. Prisoners are safe from exposure to substance use and effective drug supply reduction measures are in place.

3.28 In our survey, 37% of prisoners said it was easy to get hold of drugs. Their availability had increased, evidenced by 27% testing positive in mandatory drug tests, compared with 14% at our last inspection. There had also been a recent rise in the number of prisoners requiring hospital treatment due to the use of illicit drugs. We were told staff corruption and smuggling through social visits were the primary sources of these drugs.

3.29 Leaders were not fully aware of the emerging threats. There had been over 8,700 intelligence reports submitted to the security department in the previous 12 months, but staff shortages had created a backlog. About 160 reports had not been acted on and some were weeks old, even though they concerned serious issues involving weapons or drugs on the wing.

3.30 There were other gaps in security procedures. A searching team was frequently redeployed to other tasks and in the months before our visit, for example, only 40% of requested cell searches had taken place. Despite ongoing concerns about corruption, staff were not searched often enough. There was no enhanced gate security and checks on staff and visitors entering the prison were inadequate.

3.31 Some security measures were disproportionate, such as single cuffing of new arrivals from the escort vehicle, as well as the routine strip-searching of prisoners returning from an outside escort when there was no intelligence to support this.

3.32 Five prisoners convicted of offences under the Terrorism Act (TACT) were discussed at monthly pathfinder meetings, chaired by the head of security. They were well attended by different partners. However, leaders had allowed TACT prisoners to access the text messaging service without safeguards being in place to monitor its use (see paragraph 6.19).

Safeguarding

Expected outcomes: The prison provides a safe environment which reduces the risk of self-harm and suicide. Prisoners at risk of self-harm or suicide are identified and given appropriate care and support. All vulnerable adults are identified, protected from harm and neglect and receive effective care and support.

Suicide and self-harm prevention

3.33 There had been 14 deaths in custody since our last inspection, including six self-inflicted deaths, three of which had taken place in quick succession in March 2023. Levels of recorded self-harm were high. There had been 590 incidents in the previous 12 months, and the number had been on a slight upward trajectory in recent months. The recorded rate was similar to other category B training prisons.

3.34 Prisoners and staff we spoke to told us self-harm was a result of the uncertainty and changes facing the prison, as well as bullying, debt and prisoners not being able to get help with basic requests. However, leaders had not sufficiently analysed data to be sure they had an accurate view of the reasons for self-harm. There was no overarching strategy or action plan, leadership in the safety department had changed twice during the transition from Serco to Sodexo, and safer custody officers were routinely redeployed. Meetings were not always well attended, did not consider trends over time, and showed too little evidence of setting useful action.

3.35 Recommendations from the Prisons and Probation Ombudsman following deaths in custody were not routinely reviewed to make sure implementation was effective over time. While there had been some early lessons learned from the most recent incidents, not enough action had been taken.

3.36 Too few serious self-harm incidents were investigated so lessons could be learned. Despite a large number of prisoners subject to constant supervision, and about 50 incidents of self-harm requiring hospital attendance in the previous year, only three incidents of serious self-harm had been investigated. Following the transition to the new contract delivery company, leaders no longer held copies of investigation reports.

3.37 Prisoners subject to constant supervision were not offered any purposeful activity or regime and there was insufficient interaction between the officer and prisoner. Although anti-ligature clothing had been used, leaders could not tell us how often and did not have oversight.

3.38 A large number of prisoners were subject to ACCT case management. There was too little other support for them apart from this process. Many had little to do and 57% of those subject to ACCT case management were unemployed.

3.39 ACCT documentation was completed to a reasonable standard, but the case manager frequently changed, which prisoners told us undermined the effectiveness of their case reviews. In our survey, only 36% of prisoners on an ACCT said they felt cared for by staff, and many we spoke to told us that they were struggling and that wing staff lacked empathy.

3.40 The buddy scheme for prisoners in crisis (similar to Listener schemes in public prisons, whereby prisoners trained by the Samaritans provide support to fellow prisoners) was not well used or sufficiently well embedded. There was no evidence of call outs being arranged at night, and buddies told us they sometimes had to offer support through a cell door, which was inappropriate.

3.41 The well-being room provided some vulnerable men with a peaceful environment and was a welcome initiative. It was run by the mental health team and a safer custody officer and was valued by those who used it. (See paragraph 4.69.)

Well-being room

Protection of adults at risk (see Glossary)

3.42 Managers had not made any links with the local safeguarding adults board despite there having been a number of concerning cases. Those in attendance at the safety intervention meeting discussed some of them, but it was unclear what action was taken as a result. Some staff said they would refer safeguarding concerns to the safer custody team, but we were not confident that all staff knew what to look out for.

Section 4 Respect

Prisoners are treated with respect for their human dignity.

Staff-prisoner relationships

Expected outcomes: Prisoners are treated with respect by staff throughout their time in custody and are encouraged to take responsibility for their own actions and decisions.

4.1 In our survey, 67% of respondents said staff treated them with respect, which was similar to the findings from our last inspection and other category B prisons. We saw some positive and supportive interactions, and staff generally knew the prisoners in their care. The transition to a new provider had meant that some staff had moved on. Some of those who remained were anxious about the change of provider and mistrusted the new leadership team; the disillusionment and low morale was reflected in our staff survey results. We were told repeatedly that some officers behaved in an unacceptable manner, such as making inappropriate comments to prisoners.

4.2 Prisoners were often not supervised well enough on the wings or as they moved around the site. We saw too many breaking rules, such as openly vaping or not adhering to dress codes, which was not challenged by staff. Some officers were distant and disengaged, and prisoners became frustrated as their very basic requests went unanswered.

4.3 Too little key work (see Glossary) was being delivered and the situation had deteriorated further since January 2023. While 89% of prisoners told us they had a key worker, only about half of them (45%) said they were helpful. We saw staff who were often overwhelmed – they told us this affected their interactions with prisoners. Many key work sessions were not sufficiently good and rarely addressed sentence progression (see paragraph 6.13). Quality assurance processes were not rigorous enough to promote improvement.

4.4 Peer workers, who held a variety of roles across the prison, were used well. They included the prisoner advice line (PAL) workers, Insiders (prisoners who introduce new arrivals to prison life), the buddy scheme to support prisoners in crisis and equality representatives. Some were very knowledgeable and provided a very good service to their community, particularly those who responded to PAL calls, which prisoners could access from in-cell phones. We watched the PAL workers answering many calls and they addressed a wide range of issues carefully and politely. They had access to information to inform their responses and were able to advise prisoners on what they could do next. The reasons for calls varied, but those we heard were mainly about the regime, access to the gym and problems with medication.

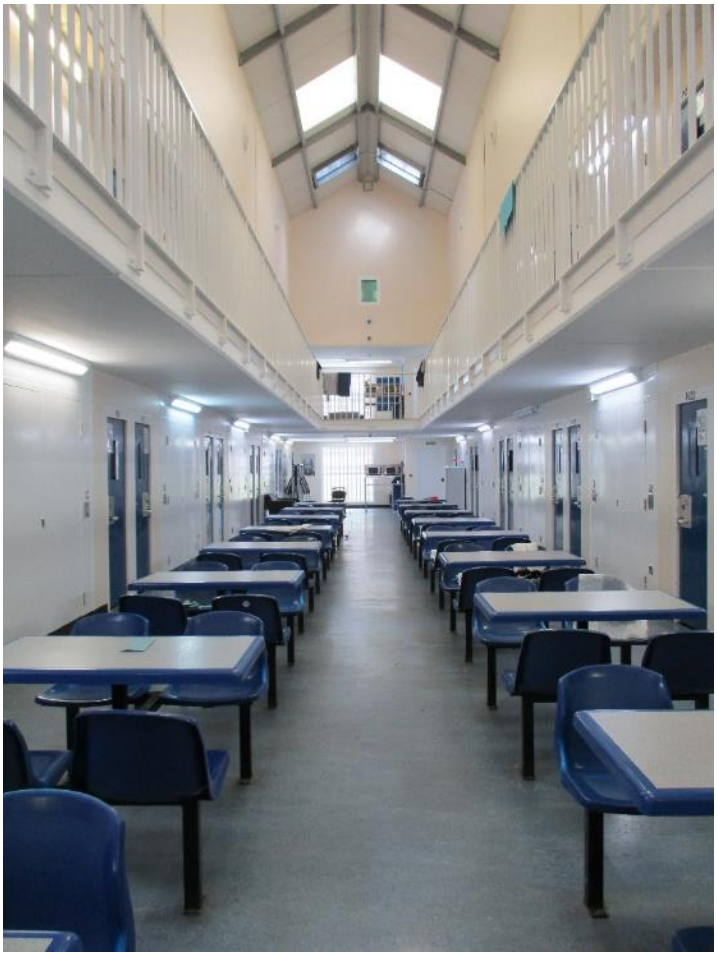
(See paragraph 1.10.) Other peer workers did not always receive adequate training or support to carry out their roles effectively.

Daily life

Expected outcomes: Prisoners live in a clean and decent environment and are aware of the rules and routines of the prison. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair.

Living conditions

4.5 The external environment and grounds were well maintained and most communal areas in the relatively modern living units were clean and tidy, but a few remained grubby and had ingrained dirt on the floors, walls, and stairways. There were few, if any, noticeboards on any of the wings to inform prisoners about available services.



Residential communal area

External areas

4.6 There were no shared cells and cells were generally well equipped. Most cells had new in-cell technology, which allowed prisoners to make applications and contact prison departments, although some had still not received this upgrade because of supply chain issues. Prisoners without the in-cell technology had access to electronic kiosks on landings to make requests or order from the prison shop and choose menu items. Access to cleaning material was adequate, and most prisoners made good use of furnishings and equipment to personalise their cells.

4.7 In our survey, almost all prisoners (95%) said they could shower every day, compared with 73% in other similar prisons. Three of the wings had in-cell showers. The other two original wings relied on communal shower areas. Although generally clean, they lacked privacy and in some, the flooring was damaged.

4.8 In our survey, prisoners were more positive about how quickly staff answered the cell bell than previously, and 36%, compared with 9%, last time said it was answered within five minutes. Response times had recently improved and were currently good, with less than 5% of responses being recorded as taking over five minutes. We saw wing patrols responding to cell call bells promptly throughout the inspection.

4.9 Most prisoners wore their own clothes, and laundry facilities on all wings were sufficient for at least one load per prisoner per week. Prison-issue clothing was available for those who chose to wear it. Access to stored property was reasonable but as at the last inspection, newly arrived prisoners sometimes had to wait weeks for their property to arrive from their previous prison.

Residential services

4.10 In our survey, only a quarter of respondents said the food was good or very good, which was much worse than in 2018 (63%). The new contract delivery company (Sodexo) had changed the menu. It was varied and included healthy options, but consultation was very limited. There had been no recent food survey and there was little evidence of discussion at the main prisoner forum.

4.11 The kitchen was clean and in good order. Meals were not usually served early, but food often remained on hot trollies for lengthy periods before service which led to a deterioration in quality. Few serveries were in full working order, but the meal service was too often poorly supervised. We routinely saw incorrectly dressed prisoners, inequitable portions being given out and even vaping at and behind serveries. We also found serveries were left dirty for long periods after the food service and that hot food trolleys were not routinely cleaned. Hardly any temperature checks were undertaken, and food comment books were not available at the point of service.

4.12 Prisoners working in the kitchen could not gain formal qualifications, even though the population was serving long sentences. Self-catering areas were provided in all living units, but some microwaves were in a poor state of repair and cleanliness.

Wing microwave

4.13 In our survey, fewer respondents than at similar prisons and at the last inspection (29% compared with 50% and 53%) thought the shop sold what they needed. Prisoners from ethnic backgrounds were similarly negative. These responses were likely due to prisoners' much-reduced access to catalogue orders for electronics, books, clothing, and hobby

materials following changes in the procurement process. Some catalogue items took over three months to arrive.

4.14 Initial access to general shop items remained good and new prisoners could receive their first order on the day after their arrival (see paragraph 3.4). The onsite shop worked hard to provide all prisoners with regular access to goods.

Prisoner consultation, applications and redress

4.15 Although arrangements for consulting prisoners were well organised, they rarely led to a meaningful improvement. A weekly prison council meeting was chaired by the deputy director, which prisoner representatives from across the wings attended regularly. However, the issues that prisoners raised repeatedly, such as their frustrations with the regime and limited access to exercise yards, remained unresolved. Representatives we spoke to were dissatisfied with this lack of change.

4.16 Prisoners could make applications easily through the kiosk system on every wing or in-cell technology if they had it. Most applications were made to the health care and education departments. Too many responses were late and, in our survey, only 23% of prisoners said applications were usually dealt with within seven days. During the inspection over half of responses were overdue.

4.17 The complaints system was ineffective and too many prisoners lacked trust in the process. In our survey, only 43% of prisoners said it was easy to make a complaint, which was worse than at the last inspection (65%) and compared with similar prisons (69%). More (51%) than at other category B training prisons (35%) also said they had been prevented from making a complaint.

4.18 There had been over 2,280 complaints in the previous year. Most were about residential issues on the wing, health care and lack of access to accredited programmes. Complaint forms were not readily available on every wing. Responses to complaints were often late and did not always address prisoners' issues. Complaints that were about violence, bullying or threatening behaviour were not always answered by a manager or followed up appropriately.

Equality, diversity and faith

Expected outcomes: There is a clear approach to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relationships. The distinct needs of prisoners with particular protected characteristics (see Glossary) and any other minority characteristics are recognised and addressed. Prisoners are able to practise their religion. The chaplaincy plays a full part in prison life and contributes to prisoners' overall care, support and rehabilitation.

Strategic management

4.19 The effective promotion of equality had lapsed since February 2023 and was only just restarting. There was no current strategy or action plan and, since Sodexo had taken over, there had been no equality management meetings, no data analysis to identify or address differential treatment and no forums with prisoners with protected characteristics. Data we saw suggested there were areas of disparity, including in the use of segregation and force, which affected those under the age of 25 and prisoners from black and minority ethnic backgrounds.

4.20 During the inspection, discrimination incident reporting forms (DIRFs) were not freely available on most wings, which made it difficult for prisoners to make a complaint. While 70 DIRFs had been submitted in the year to the end of April 2023, we were only able to review the 19 submitted in the current year. Investigations were mostly thorough, but responses were often late and sometimes lacked empathy and an understanding of the individual's experience. Quality assurance was not robust enough and there was no independent scrutiny.

4.21 Leaders were aware that the staff group lacked diversity and prisoners said this was a concern. Equality was not promoted well across the prison and, while equality representatives had just been recruited, they had received no training and lacked an understanding of their role.

Protected characteristics

4.22 With a few exceptions, the experiences of prisoners with protected characteristics who responded to our survey were broadly in line with those of the comparator groups. However, significantly fewer Muslim prisoners felt staff treated them with respect.

4.23 About two fifths of the population were from black and minority ethnic backgrounds. While most of those we spoke to were broadly content with the support they received, some said staff treated them differently and many said they lacked a cultural awareness.

4.24 During the inspection, 11% of the population were foreign nationals. The small number who spoke little or no English were marginalised and isolated. Professional telephone interpreting was used well by health care and offender management unit staff but too infrequently by

officers. Most wing staff used another prisoner to interpret, which could compromise privacy and confidentiality. Little information was available in languages other than English.

4.25 An officer had some oversight of foreign national prisoners and liaised with Home Office immigration officials to convene surgeries, but they were often cancelled. The officer was also able to direct prisoners to a range of legal support if needed.

4.26 Prisoners with disabilities were generally identified on arrival, but in some cases ongoing support was inadequate. There were few adapted facilities or individual adjustments, such as grab rails or shower aids. We found some prisoners' needs were not being met, for example, there was a lack of social care. A peer-led carer scheme apparently operated, but no prisoners who would have benefited from this additional help had an allocated carer during the inspection. (See paragraph 4.62.)

4.27 Officers' knowledge of personal emergency evacuation plans (PEEPs) was not good enough. PEEPs were not always readily available and not enough staff were aware of who needed assistance.

4.28 Good health-led support was available for neurodivergent prisoners and veterans in custody. Health care staff developed care plans for prisoners with neurodivergent conditions, but most officers lacked an awareness of prisoners' individual needs. The Veteran Care Through Custody programme was impressive. The health provider, in partnership with the charity Care After Combat, worked directly with prisoners who had been in the armed forces to promote their mental and physical well-being. There were monthly forums involving prisoners and prison and specialist health staff. Veteran prisoners could receive a health care assessment and support to help them deal with trauma. The group was greatly appreciated by those who attended. (See paragraph 1.11.)

4.29 There was a lack of support for those under 25, gay and bisexual prisoners and those from Gypsy, Roma and Traveller backgrounds. Other than an over 50s gym session, there was limited support for older prisoners. Retired prisoners were unlocked during the working day.

Faith and religion

4.30 The chaplaincy was under-resourced. While the team met the needs of prisoners from most faiths and provided pastoral care to many, it was not as active or visible as we often find.

4.31 The multi-faith centre was pleasant but relatively small. In our survey, 80% of prisoners said they could attend services if they wanted to, more than in similar prisons (66%). Despite this we found that too many prisoners were denied weekly access to services because of cohorting to deal with ongoing safety and security concerns. Prisoners could,

however, take part in a variety of prayer and study classes, and a wide range of religious festivals was celebrated.

4.32 There was some positive joint working with faith-based organisations in the community to support prisoners on release.

Health, well-being and social care

Expected outcomes: Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.

4.33 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) (see Glossary) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC took enforcement action in the form of a warning notice, served to the provider on 8 June 2023 under Section 29A of the Health and Social Care Act 2008. The regulatory breaches will be followed up with the health care provider.

Strategy, clinical governance and partnerships

4.34 Despite there being a conscientious team, long-standing staff shortages continued to have a detrimental impact on the delivery of an effective health service.

4.35 NHS England (NHSE) held regular contract review meetings and had increased its level of scrutiny following a clinical quality visit a year earlier, where a range of concerns was highlighted. At a recent inquest into a death in custody in 2019, the coroner had been very critical of health care services. Some limited progress had been made in addressing issues raised by NHSE and recommendations from the Prisons and Probation Ombudsman's death in custody reports, but some recurring themes had only recently been addressed. There had also been very little progress made on implementing health care recommendations from the previous inspection in 2018.

4.36 A health, social care and well-being assessment was produced in November 2022 in preparation for the retendering process with a new health contract due to start in April 2024.

4.37 Partnership working was poor and there had been no local delivery board since Sodexo took over the prison contract, although dates for future meetings were established during the inspection.

4.38 The interim head of health care provided good leadership and had had a stabilising effect in the brief time she had been in post, which staff valued. However, the previous gaps in leadership meant that strategic oversight of the service was limited, and governance arrangements were weak.

4.39 Relationships between health and prison staff were strained. Health care staff did not feel respected, and prison staff did not always take their clinical judgement into consideration, creating potentially adverse outcomes for patients. Safeguarding concerns previously raised by health care staff had not been investigated, which we pointed out to the new director during the inspection. We found several examples of the prison failing to arrange health interventions. Recent changes to the daily regime had not sufficiently taken men's health care needs into account. For example, there was not always enough time scheduled for prisoners to be issued with methadone and attendance at some clinics had been adversely affected.

4.40 Clinical and managerial supervision and compliance with mandatory training were below expected levels. There had been some delays in investigating serious incidents, which meant there was a potential risk of issues occurring again, and this had happened in one case we reviewed.

4.41 A new initiative, which involved a health care administrator phoning all self-isolating prisoners to check on their health needs and pass information on to the relevant clinical team to follow up meant that they received the health support they required. (See paragraph 1.12.)

4.42 We observed caring and professional interactions between staff and patients. Patients we spoke to were mostly positive about the care they received but many were frustrated by the lengthy waits particularly to see the dentist and the GP, which had been raised at our last three inspections.

4.43 Health care complaints were not always investigated in a timely manner, and we found 10 over the previous year that had not been investigated or had not received a response. Responses made to other complaints were polite, but there was no quality assurance or oversight of the process.

4.44 Clinical areas were generally clean and well equipped but did not fully comply with infection control standards. For example, there were issues with the flooring and flaking paint, and some sinks lacked the appropriate elbow taps.

4.45 Some staff had not received their hospital life support training since 2021, although a session was scheduled during the inspection. Emergency resuscitation bags were on each house block, and we were told they were checked every week. However, we found some out-of-date items in one bag, which had not been checked for two weeks.

Promoting health and well-being

4.46 There was no joined up, prison-wide strategy for health promotion that involved key services such as the gym, health care or catering.

4.47 Limited health promotion information was displayed across the prison and in the health centre. The only health promotion leaflets available

were in English, although staff said they would use telephone interpretation services during consultations when needed.

4.48 There were no health champions to help promote healthy lifestyles, patient feedback opportunities were limited and there was no patient forum.

4.49 Immunisations and vaccinations were offered, but the uptake was low. Preventative screening programmes, including retinal screenings and those for aortic abdominal aneurysms, were available.

4.50 Blood borne virus testing was now offered during initial and secondary screening. The Hepatitis C High Intensity Test and Treat programme team had recently identified some prisoners who had tested positive, and they then received the necessary treatment.

4.51 Visiting specialists regularly delivered a good range of sexual health services. Condoms could be requested through in-cell technology and the electronic kiosks.

4.52 There was no support for those wishing to stop vaping.

Primary care and inpatient services

4.53 Data from October to March 2023 showed that not all new arrivals received an initial health screening or secondary health screening within the National Institute for Health and Care Excellence seven-day guidance timeframe. This meant that any potential health risks could have been overlooked. We were informed that this had recently improved. The interim head of health care planned to undertake a further review to make the process more robust.

4.54 The service had 24-hour nursing cover, but staff shortages had made it difficult to provide this level of support in recent months. NHSE was piloting the service without night cover for a three-month period from April to June.

4.55 The GP contract had just been increased from 18 hours to 30 hours a week to cater for those in the segregation unit. Cover was provided by three regular GPs and an experienced advanced nurse practitioner. Waiting times had been reduced, but they were still too long at about four weeks.

4.56 An appropriate range of primary care services was available as was access to allied health professionals, such as an optician and physiotherapist. Patients used the wing kiosks or in-cell technology to make appointments. There had been a backlog of appointments being processed, which was decreasing, but, along with high non-attendance rates for some clinics, it had contributed to lengthy waiting times.

4.57 A lead nurse managed patients with long-term conditions well with oversight from the GPs and physical health matron. Evidence-based care plans were in place and reviewed regularly.

4.58 Administrative processes for managing external hospital appointments were good. A number of appointments had been rescheduled because of NHS strikes or patients refusing to attend. However, we also came across several examples of patients waiting too long to be taken to hospital for suspected fractures and for some planned outpatient appointments. Prison staff cancelled some escorts to hospital on the day without consulting health care staff to prioritise who should attend. This was unacceptable and had delayed urgent appointments to diagnose potentially significant health issues.

4.59 All patients being released or transferred from the prison were seen in reception by a nurse who provided health advice and medication, if required.

Social care

4.60 There was no memorandum of understanding or information-sharing agreement between the prison and Nottinghamshire County Council. Prison leaders had not established links with the local authority and there was no governance or framework in place for requesting a social care assessment, which was unacceptable.

4.61 No prisoners were receiving a social care package (see Glossary). Self-referrals to the local authority were not advertised or promoted, and prison staff did not know whom to contact if they felt a prisoner needed social care.

4.62 We identified a few men whose needs were not being met and who were relying on and paying other prisoners to help them with their personal care, which was a concern and posed potential safeguarding risks. There was no formal recruitment, training, or supervision in place for peer-led carers and many prison staff did not know where existing ones were located. (See paragraph 4.26.) Personal alarms were not available so prisoners could not summon assistance in an emergency.

4.63 A local authority representative said its staff worked with partner agencies to make sure information was shared with the receiving prison or relevant local authority when prisoners were due for transfer or release.

Mental health care

4.64 The mental health team did not have enough staff to meet the high level of need within the prison. Competent and dedicated staff were well supported by an experienced team leader, but vacancies and the need to deal with day-to-day crises meant the team was unable to deliver the level of care required.

4.65 There was an open referral system and 90% of routine assessments were undertaken within five days. A nurse screened all referrals every day and those requiring urgent support were seen within 48 hours. A weekly multidisciplinary meeting reviewed all new referrals as well as any patients raised by the team for discussion.

4.66 In total, the mental health team supported approximately 200 patients, about three quarters of whom were receiving input from a psychiatrist. Three visiting psychiatrists offered three sessions per week. Demand for psychiatry appointments was increasing and a waiting list was being introduced.

4.67 Patients prescribed mental health medication were held on a caseload, which was reviewed every four or 12 weeks. Those requiring more intensive support were allocated to a nurse for more regular, structured interventions. Nursing staff's ability to provide this care was hindered by their day-to-day management of more urgent tasks, such as medicines administration or responding to prison requests to see patients in crisis.

4.68 A mental health nurse also attended all initial assessment, care in custody and teamwork (ACCT) case management reviews for those at risk of suicide or self-harm. However, poor communication from the safer custody team and a strained working relationship with prison staff often resulted in nurses being unaware of times and venues, wasting clinical time and affecting their ability to see patients on their caseloads. A meeting was scheduled during the inspection between health care managers and the prison to develop a new process for attendance at ACCT reviews. A mental health nurse reviewed patients held in the segregation unit where required.

4.69 A psychologist and assistant psychologist visited the prison every week. There was a significant backlog of over 100 patients waiting up to a year to access psychological therapy, including group work. An assistant practitioner ran sessions for patients in the well-being room in partnership with a safer custody officer. They provided patients with therapeutic activities, and a sensory room offered a calm environment. (See paragraph 3.41.)

4.70 A neurodiversity pathway offered excellent support to men with attention deficit/hyperactivity disorder and autism diagnoses, but a large number of patients were waiting for an assessment.

4.71 In the previous 12 months, 11 patients had been assessed as requiring a transfer to an external hospital under the Mental Health Act, but only one had been transferred within the recommended timeframe.

Substance misuse treatment

4.72 An integrated clinical and psychosocial substance misuse service was available, but staffing vacancies affected the range of support provided There were 53 patients receiving opiate substitution treatment (OST) and 86 receiving support from the psychosocial team.

4.73 The manager attended monthly drug strategy meetings and a new drug strategy had recently been produced. Large numbers of prisoners were suspected of being under the influence of illicit substances, which was discussed at the meeting. (See paragraph 3.28.) The service offered a pathway of care, which included health care staff visiting the wing,

prison staff carrying out observations and the psychosocial team providing subsequent targeted support. On occasion, wing staff failed to report prisoners suspected of being under the influence of drugs to the substance misuse team.

4.74 The administration time of methadone had been changed to later in the morning even though patients still had to attend earlier to receive other medicines, which affected their attendance at work and other activities. It also reduced the amount of time available for OST administration, which meant that some patients did not receive it until much later in the day, which posed a clinical risk. Many patients we spoke with were complimentary about the individual support they received despite their frustration with regime changes.

4.75 Care was delivered depending on the patient's needs and prescribing was flexible. A visiting non-medical prescriber (NMP) undertook regular reviews with the clinical team, but not with the psychosocial team. In the NMP's absence, staff sometimes had to find another prescriber which sometimes proved challenging. There was no dedicated recovery wing at the prison, which was poor.

4.76 Prisoners could refer themselves, but the service was not well advertised. There were no peer workers or groups such as Narcotics Anonymous, which meant prisoners' recovery was not fully supported.

4.77 Care plans varied in quality, but this was being addressed. A range of one-to-one psychosocial work was available. Group work had only restarted recently, and delivery was inconsistent due to the lack of room availability and staffing pressures.

4.78 Joint working with community services supported prisoners on release, and naloxone (which rapidly reverses an opiate overdose) was available on the day of their release.

Medicines optimisation and pharmacy services

4.79 A community pharmacy supplied medicines. Collection of delivered medicines took place outside the prison. There was evidence of supplies arriving up to a week after they were needed. This meant until the patient's named medicines arrived from the external pharmacy, they received it from stock supplies on a supervised daily basis, rather than in possession.

4.80 Medicines were administered twice a day from dedicated hatches on the wings. Some of the cupboards used for storage were not suitable. The regime required most medicines to be administered during morning and afternoon rounds, although some received them at lunchtime and at night according to their need.

4.81 Administration was not well supervised, and many prisoners crowded around the hatch, despite an officer being present. Some pharmacy technicians were not following written procedures, and their medicine

administration competency had not been assessed for over a year, which the provider stated was a minimum requirement.

4.82 All medicines that were not in possession were administered from stock, rather than being issued as patient-named medicines. This was poor practice and the provider planned to change it; this needed to be done as soon as possible. Some medicines supplied were in an unlicensed form, even when a licensed alternative existed, which was unacceptable.

4.83 Medicines were kept in a dedicated pharmacy room. The system for monitoring stock levels was not robust. Not all the medicine cupboards had locks and it was not possible to determine when medicines had been removed from stock and by whom. Medicines were disposed of in large bins that were not tamper proof. Controlled drugs were stored securely and safely in the pharmacy room.

4.84 Medicine risk assessments were in place, but we found cases where prescribers ignored them, regularly prescribing seven days' medicine to those who had been risk assessed as being able to have medication 28 days in possession. In one case a patient who was not supposed to be given in-possession medicines was issued with them.

4.85 No pharmacist attended the prison to provide professional oversight, patient consultation or pharmacy input into meetings. Robust clinical checks did not take place following prescribing. Medicines with narrow therapeutic levels (where a small difference in dose can potentially cause an adverse reaction) were not monitored. The supplying pharmacy was not able to have a complete medical picture of the patient, and these checks could not be expected to be carried out by pharmacy technicians.

Dental services and oral health

4.86 A good range of community-equivalent dental treatments was available, including oral health advice, but a large number of appointments were not facilitated because of regime problems and a lack of escorting prison officers, which severely affected dental clinics. Over 100 patients had waited up to a year for a routine appointment, which was excessive.

4.87 A dental nurse and dentist were on site four days a week, and a dental therapist provided two sessions per week. A newly recruited dentist was due to take up post, and commissioners had recently agreed to increase the number of dental sessions to reduce the backlog.

4.88 As a result of the lengthy waiting times, a large number of patients reported significant pain. The dental nurse triaged those reporting pain every day and referred them for antibiotics or pain relief where appropriate. However, managing urgent care affected the team's ability to see new patients.

4.89 The dental clinic was well equipped and had a separate decontamination area. Equipment was serviced and maintained appropriately. However, the dental environment did not meet infection control standards because of issues outside the provider's control, which had been escalated to the prison for resolution.

4.90 Good governance arrangements were in place and patients gave positive feedback about the service they received when they were eventually able to access it.

Section 5 Purposeful activity

Prisoners are able and expected to engage in activity that is likely to benefit them.

Time out of cell

Expected outcomes: All prisoners have sufficient time out of cell (see Glossary) and are encouraged to engage in activities which support their rehabilitation.

5.1 In our roll checks, we found 42% of the population locked up during the working day, which was far too many for a training prison. Prisoners had much less time out of cell than at the last inspection. A new regime had just been implemented by the director to try to make best use of limited staffing numbers. Prisoners employed full time could be unlocked for just under nine hours a day. This applied to relatively few, with many others spending about five hours out of their cells on weekdays. For the many unemployed prisoners it was as little as three hours.

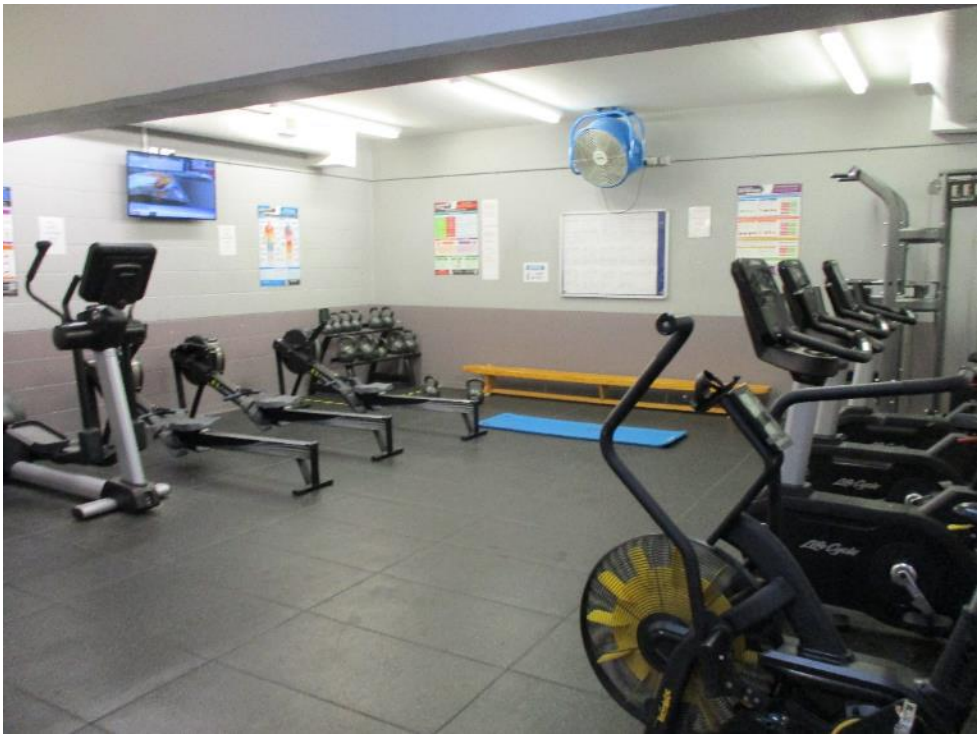
5.2 There were sporadic periods of unlocking during the day, which strongly resembled conditions imposed during the pandemic. We witnessed delays, which further curtailed periods of unlocking and reduced access to the already insufficient work and learning opportunities.

5.3 Most prisoners had access to two 30-minute periods of exercise in relatively small yards. Staff and prisoners we spoke to disliked the split sessions and would have preferred one longer period.

5.4 The prison operated daily sessions referred to as 'structured on-wing activity' but there was little for prisoners to do, no evidence of any structure, and sessions amounted to free time to play pool, snooker, chess and table tennis. There were no opportunities for evening association.

5.5 In our survey, 43% of prisoners said they could use the library once or more a week, which was significantly higher than in similar prisons and in 2018. Although there was no formal monitoring of library use, data for April 2023 showed that it was under-used with an average of just five prisoners a day visiting. The library only opened on week days, while education classes ran, there was no access in the evenings or at weekends and it was closed during the inspection. Literacy was not promoted well enough and there were no activities or initiatives to encourage prisoners to read (see also paragraph 5.17). Provision for the foreign national community was too limited.

5.6 The PE facilities were good. In our survey, 53% of prisoners said they could access the gym twice a week, which was better than similar prisons (25%). However, use of PE facilities was not monitored and classes we observed were poorly attended. The sports field was being used for the first time in a considerable period.



Gym and cardiovascular room

5.7 A new PE timetable aimed at diversifying the provision was implemented during the inspection, but it was too soon to assess how effective it was. Prisoners applied for sessions through the wing kiosks or in-cell technology and spaces were allocated on a first-come-first-served basis. This led to considerable frustration among many prisoners who believed their access was being restricted.

5.8 The sports academy was well regarded and worked with small groups of prisoners to deliver helpful qualifications. (See paragraphs 5.23 and 5.27.)

Education, skills and work activities

This part of the report is written by Ofsted inspectors using Ofsted's inspection framework, available at https://www.gov.uk/government/publications/education-inspection-framework.

Ofsted inspects the provision of education, skills and work in custodial establishments using the same inspection framework and methodology it applies to further education and skills provision in the wider community. This covers four areas: quality of education, behaviour and attitudes, personal development and leadership and management. The findings are presented in the order of the learner journey in the establishment. Together with the areas of concern, provided in the summary section of this report, this constitutes Ofsted's assessment of what the establishment does well and what it needs to do better.

5.9 Ofsted made the following assessments about the education, skills and work provision:

Overall effectiveness: Inadequate

Quality of education: Inadequate

Behaviour and attitudes: Inadequate

Personal development: Inadequate

Leadership and management: Inadequate

5.10 Recently appointed leaders had not prioritised designing an effective curriculum that met the needs of prisoners. There was no focus on meeting local, regional, or national skills needs. Most educational programmes were in English, mathematics, art and graphic design, painting and decorating, and sports, with a very small number having access to an English course for speakers of other languages.

5.11 The curriculum was not sufficiently ambitious and did not support prisoners to meet their potential. For example, they could not progress past level 1 in most courses, which meant they had few opportunities to progress.

5.12 Prisoners could not gain useful, accredited qualifications while at work. Leaders worked with a few employers such as the National Health Service and DFS Furniture to provide work in upholstery, textiles, and packaging. Other aspects of work, such as cleaning, serviced the prison population. However, prisoners at work did not have the opportunity to translate the skills they had learned, into qualifications

that would be recognised by employers. Many who undertook cleaning jobs did not have the qualifications they needed to carry out their work efficiently or safely.

5.13 Leaders did not provide sufficient places in education, skills or work to meet the population's needs. In addition, it took too long to allocate prisoners to available spaces. The limited curriculum demotivated prisoners and they waited too long to attend activities that might not have helped them meet their resettlement needs. However, leaders had successfully responded to the previously unfair local pay rates. As a result, pay did not disincentivise education.

5.14 Prisoners' attendance at education and vocational training was poor. Many did not attend their classes in education. Their attendance at work was better but still needed further improvement. The new regime affected prisoners' ability to arrive at sessions on time. This delayed the start of the sessions and disrupted learning.

5.15 Leaders and managers did not provide prisoners with effective careers advice and guidance. During induction, managers collated information on prisoners' English and mathematics abilities. However, they failed to consider or discuss their career goals. When due for release, prisoners did not receive information to support their employability skills. For example, they were not taught how to apply for jobs online, set up an email address or write a curriculum vitae. As a result, prisoners were not prepared effectively for release or resettlement.

5.16 There was no effective process for supporting prisoners with additional learning needs. Superficial assessments were in place, but further detailed assessments had often not been carried out. Consequently, teachers did not know how to support prisoners. Therefore, the vast majority did not get the learning support they needed in education or the wider prison.

5.17 Leaders had made slow progress on the implementation of an effective reading strategy. No specific education classes were available for non-readers or emerging readers. No additional in-class or one-to-one support was available. There were no Shannon Trust peer mentors to help others with their reading. Leaders had not yet implemented an effective initial assessment in reading. Consequently, they did not have a thorough understanding of the population's reading needs.

5.18 Quality assurance processes were not effective. When the new provider took over, they completed a full quality assurance audit. They observed teachers in the classroom and reviewed written feedback and marking. Following these activities, they put in place new measures. However, they did not take the time to understand the impact or the effectiveness of those changes on the quality of the education provided. Because of this, they were not yet sure about the current issues affecting the quality of education. In addition, recommendations made at the previous inspection had not been appropriately addressed or rectified.

5.19 Mentors were not deployed effectively in classrooms. Prisoners took qualifications to become mentors in education. However, they did not consistently understand how to apply the skills they had learned in practice. Teachers did not routinely explain what they expected of them in sessions. As a result, they were not consistently effective in supporting learning.

5.20 The new prison education provider, Novus, worked closely with prison leaders to understand the educational needs of the population. Their immediate focus was to determine their requirements for English and mathematics. However, this objective was to the detriment of other aspects of education such as meeting prisoners' support needs effectively or assessing their reading skills. As a result, many prisoners did not get the valuable support they needed and did not make the progress they were capable of.

5.21 Teachers did not have access to comprehensive information to provide evidence of prisoners' starting points. Teachers were often provided with a list of prisoners' English and mathematics capabilities. However, they failed to use them successfully to plan learning. Too often, teachers followed the awarding body specifications and did not logically order learning to build on prisoners' needs, knowledge or skills. As a result, prisoners did not develop their knowledge or skills at the rate of which they were capable.

5.22 A few teachers used effective teaching strategies. For example, those delivering level 1 behaviour change, used questioning successfully to assess prisoners' understanding. They used examples effectively to embed knowledge and apply context to information. As a result, these prisoners could relate to the information provided and remembered more.

5.23 Teachers in the sports academy, I-media and art, demonstrated excellent subject knowledge. They used their experience to enable prisoners to understand key concepts. They presented information clearly. In many cases, they supported prisoners to develop a deeper understanding of their subject. For example, in art, prisoners could take part in enrichment activities, which included access to virtual exhibitions. They could also read trade publications. In I-media prisoners successfully supported other prisoners by filming them reading stories for their children.

5.24 Tutors in workshops did not routinely check or correct spelling and punctuation in prisoners' workbooks. Therefore, prisoners did not learn from their mistakes or understand the changes they needed to make. As a result, they did not develop the written skills they needed for their future.

5.25 Leaders did not make sure that staff held the relevant qualifications needed to support prisoners' educational needs. For example, only a few tutors in workshops held formal teaching and assessing qualifications. Leaders in education and skills had successfully put in place opportunities for teachers to develop their practice. However,

only one teacher had qualifications or experience in phonics. As a result, prisoners were not supported to meet their potential or gain formal qualifications.

5.26 Leaders did not plan an appropriately broad curriculum. For example, activities and opportunities to promote the fundamental values of tolerance and respect were not used in sessions and, as a consequence, prisoners demonstrated a very poor awareness of them. Most prisoners did not know how to access support for their mental health needs, nor did they receive advice on how to keep themselves mentally healthy. In addition, they did not know how to develop their mental resilience.

5.27 Prisoners felt safe when attending education. They demonstrated respect for each other, teachers and visitors. They were confident about asking questions and contributed to group discussions. They worked successfully together and supported each other to share ideas. Within the sports academy, prisoners gained confidence and improved their communication skills.

Section 6 Rehabilitation and release planning

Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.

Children and families and contact with the outside world

Expected outcomes: The prison supports prisoners' contact with their families and friends. Programmes aimed at developing parenting and relationship skills are facilitated by the prison. Prisoners not receiving visits are supported in other ways to establish or maintain family support.

6.1 Most prisoners were a very long way from their home areas with only 13% coming from the East Midlands. Leaders did not know how many prisoners were not receiving visits or making contact with the outside world and there had been no analysis to cater for the needs of the population.

6.2 Support to help prisoners build relationships with children and family members was limited. There were no programmes to develop their relationship or parenting skills, but there were advanced plans to introduce them. There had been no family days from January to March 2023. The Official Prison Visiting Scheme was only just being introduced for men without visitors. There was only one part-time family engagement worker, but she was able to work extensively with social services and family courts.

6.3 The visits hall was pleasant but lacked a play area. There was a small café which sold a limited range of cold refreshments.

Visits hall

6.4 During our inspection, a new timetable had been introduced that provided more visits seven days a week but with shorter time slots. This was a source of frustration for many prisoners, particularly as many of their visitors travelled a long way to see them. Prisoners booked visits themselves using the kiosks or in-cell technology, although many said it was difficult to secure slots over the weekend.

6.5 In the previous five months, 25 prisoners had applied for a transfer to another prison to use accumulated visits (where prisoners are allowed several visits over a few days), but only two had been accepted by other establishments. A lack of available escort vehicles meant even these two transfers had not yet been arranged.

6.6 Video calls were well used. Leaders did not know how many prisoners used international video calls even though there were over 100 foreign nationals.

6.7 Prisoners had in-cell phones. A text messaging service, which most prisoners could access via in-cell technology, was extremely well used and valued, but the lack of monitoring and public protection oversight was extremely concerning. (See paragraph 6.19.)

6.8 The I-media workshop produced 'storytime' video recordings, which allowed prisoners to read out children's stories or messages to send to loved ones. Over 400 videos had been sent to families in the previous six months.

Reducing risk, rehabilitation and progression

Expected outcomes: Planning for a prisoner's release starts on their arrival at the prison. Each prisoner has an allocated case manager and a custody plan designed to address their specific needs, manage risk of harm and reduce the risk of reoffending.

6.9 The prison held a high risk, long-term population, but it was not fulfilling its rehabilitative role effectively. There were not enough places on the right accredited programmes, contact with prison offender managers (POMs) did not allow for prisoners to be sufficiently challenged about their offending behaviour and there were not enough progression opportunities in work or education. Although the number of prisoners being released was increasing, there was no dedicated team of resettlement staff.

6.10 Strategic work to reduce reoffending had largely lapsed during the handover to the new contract delivery company. There was no detailed action plan to deliver the new contract and drive improvement. The previous contract delivery company had refused to give the new leaders their population needs analysis, so the work had to be carried out again to make sure contractual agreements would meet the needs of the diverse population.

6.11 Probation officers and two probation managers had been introduced since the last full inspection, which was good and had improved risk management. However, their expertise was much too peripheral to the wider work of the prison. Staff from other departments did not attend the monthly interdepartmental risk management meeting (IRMM) regularly, they had not been provided with interview rooms where they could conduct meaningful work with prisoners, and they described wing staff as behaving dismissively towards them and their work.

6.12 Some good recent progress had been made in addressing the backlog of offender assessment system (OASys) reports and sentence plans. Sessional staff provided by a national taskforce had completed an additional 178 assessments since December 2022. Nonetheless, about a third of all plans were still more than 12 months old, which reduced their relevance and effectiveness.

6.13 Despite the introduction of probation officers, the offender management unit (OMU) was short of POMs and caseloads were high. Full-time probation officers carried about 100 cases, while Sodexo-employed POMs had about 75 each. As a result, contact with prisoners was often not frequent enough. We saw some good examples of work in a few cases, but in most instances, contact was driven by tasks like parole, rather than ongoing one-to-one sessions that focused on offending behaviour. Prisoners we interviewed expressed their frustration because they were not receiving the help they needed to achieve their sentence plan targets and were often disillusioned by their lack of

progress. Key work (see Glossary) was not good or meaningful enough to support sentence progression (see paragraph 4.3).

6.14 Prisoners on shorter sentences who were eligible for release on home detention curfew (HDC) had started to arrive at the prison. There had only been a handful of HDC releases so far, so OMU managers were still adapting to these unfamiliar processes.

6.15 About 40% of the population were serving indeterminate sentences but they had no specific support to motivate or engage them. There were no dedicated wings, consultation forums or peer workers. Most were likely to wait years before they could undertake an accredited programme because other prisoners were prioritised ahead of them.

Public protection

6.16 About 90% of the population were assessed as presenting a high risk of serious harm to others. Some important public protection information about cases had been lost when the previous contract holder left, because of problems in transferring it electronically. Many public protection measures were poorly applied and the team responsible did not include probation staff who would be specifically trained in risk assessment and management.

6.17 Far too little telephone monitoring took place to manage prisoners' risks. Only seven prisoners were having their phone calls monitored at the time of our inspection.

6.18 Not all prisoners who potentially presented an ongoing risk to children had an appropriate contact restriction in place. Despite the large number serving life sentences, and about 400 men with a history of domestic violence, only 45 were currently subject to a restriction, which meant their suitability for contact had been assessed and a decision taken about whether contact with children was appropriate. We found a number of examples in our case sample where prisoners carried clear risks, but no assessment had been completed, which meant no restrictions had been applied.

6.19 Following the introduction of new in-cell technology, about 500 prisoners had been using a text messaging system, which enabled them to send messages to the numbers on their phone account (see paragraph 6.8). None of the public protection, OMU or security staff had been monitoring the content of the messages (see paragraph 3.32) and we found examples of highly threatening and abusive messages being sent. Many POMs did not know that high-risk prisoners they were managing had access to this facility.

6.20 The number of prisoners being released was increasing and almost all presented a high risk of harm to others. The monthly IRMM had generated some good quality discussions, but it had only reviewed about two thirds of high-risk cases approaching release. It also struggled to obtain useful contributions from other departments about prisoners' behaviour, notably the security team. Most POMs'

contributions to multi-agency public protection arrangement (MAPPA) panels ahead of a prisoner's release were insufficiently analytical and did not always contain information from other departments.

6.21 Arrangements for POMs to liaise with community offender managers (COMs), identify MAPPA management levels and reduce risks ahead of a prisoner's release were not always robust, and plans were sometimes finalised much too close to the time of release.

6.22 While we saw some good examples of handovers and ongoing communication, we also checked some cases that had not benefited from the IRMM's oversight. In one, a high-risk prisoner convicted of stalking was being released 10 days later. They did not yet have any confirmed housing and no MAPPA management level had been set. In another case, a very high-risk man, with a history of domestic violence was being released about six weeks after the inspection. He had not undertaken any interventions, did not yet have any confirmed accommodation and there had not yet been a handover meeting with the COM.

Categorisation and transfers

6.23 Recategorisation reviews were too often late, typically because of a lack of input from the security department. Too many prisoners who had been recategorised to C remained at Lowdham Grange and at the time of our inspection, 66 were waiting for a transfer and about a third of them had been waiting since late 2022. Escort vehicles were often cancelled.

6.24 Too many prisoners were subject to outdated transfer holds. Of the 165 holds in place, the oldest dated back to 2009 and about half predated the pandemic, which could have led to these men staying at Lowdham Grange for far too long.

Interventions

Expected outcomes: Prisoners are able to access interventions designed to promote successful rehabilitation.

6.25 The delivery of accredited programmes had been maintained and 92 prisoners had undertaken one. However, the provision was currently undermined by the departure of most of the forensic psychology team, and only 73 prisoners were due to complete a programme in the current year, which was not sufficient to meet prisoners' needs.

6.26 The current programmes did not match the needs of the population. The most frequently delivered intervention was the moderate-intensity Thinking Skills Programme (TSP) and there were far too few places on high-intensity accredited programmes that addressed violent behaviour. Despite the level of serious violent offending within the population, in the current year only 17 prisoners were to complete either the Kaizen programme, which focuses on violence, or the

Becoming New Me + intervention, for those with learning difficulties. Among the population, at least 180 prisoners met the initial criteria for a high-intensity programme, subject to a programme needs assessment, which meant the provision was not sufficient. This projected level of need was likely to be even higher once the OMU's recently drawn up sentence plans were included (see paragraph 6.12).

6.27 The lack of enough programme spaces particularly affected indeterminate sentence prisoners. (See paragraph 6.15.)

6.28 Some high-risk determinate sentence prisoners who were not prioritised for treatment under the current HM Prison and Probation Service model would be released without completing the Kaizen programme. We were told about six of these men would return to the community in the following 12 months.

6.29 Nearly half the population had a history of domestic violence, but there were no relevant interventions for them. For example, about 100 men may have benefitted from either the Building Better Relationships or Kaizen (Intimate Partner Violence) programme, but neither were available at the prison.

6.30 Novus ran a couple of short courses to help men begin considering their attitudes, thinking and behaviour. In the previous 12 months, 175 prisoners had completed either Pro-Social Modelling or Behaviour Change programmes.

Release planning

Expected outcomes: The specific reintegration needs of individual prisoners are met through an individual multi-agency plan to maximise the likelihood of successful reintegration into the community.

6.31 The number of releases had doubled since the last inspection – 80 prisoners had been released in the previous 12 months because the prison was starting to hold those who were serving shorter sentences or who were closer to release.

6.32 Despite this, the prison had no resettlement function, which was unlikely to change. There were no dedicated resettlement staff and no housing worker on site. POMs with high caseloads had to make sure that COMs understood prisoners' resettlement needs and had made necessary referrals for provision like accommodation. Sometimes a prisoner had several different COMs in the lead up to their release, which made the situation more challenging. Planning sometimes began too close to a prisoner's release (see paragraph 6.21). Often it involved POMs completing work that should have been undertaken by the COM. The POMs lacked specialist training in housing provision but did their best to make sure that accommodation was in place on the day of release.

6.33 About half of prisoners were released to approved premises because of their risks. Some went to family or friends and 13 had been discharged to a secure psychiatric hospital in the previous 12 months. Three men had been released homeless, one of whom had presented a high risk. In one instance, when the prison had exhausted all options, a prisoner was given enough money for a hotel bed on his first night of release.

6.34 Prisoners only received basic support with managing their finances. A few had opened bank accounts with the help of OMU staff, and a Department for Work and Pensions worker visited the prison to help set up benefit claims.

6.35 Arrangements on the day of release were adequate. When we checked, reception had no spare bags for prisoners to carry their belongings in, even though they were made on site in a workshop. A taxi was arranged so prisoners could reach a nearby railway station.

Section 7 Progress on recommendations from the last full inspection and scrutiny visit reports

Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy prison.

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2018, the reception and induction of new prisoners were generally sound. The number of violent incidents was high and some were serious. Work to reduce violence was innovative but it was too early to judge its effectiveness. Hearings for the high number of adjudications sometimes lacked enquiry and too many were dismissed due to errors. The use of force and segregation was high and governance was insufficiently robust. Segregation staff knew men well but relationships were functional. Security arrangements were reasonably proportionate. The mandatory drug testing positive rate had fallen significantly in the last year. The number of self-harm incidents was high and some were serious. The quality of ACCT documentation was poor but men in crisis were reasonably positive about the care they received. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

The number of violent incidents should be reduced. The prison should engage with prisoners and other stakeholders to further their understanding of the causes of violence and to implement bespoke strategies to address them.
Achieved

The prison should reduce the number of uses of force. All incidents involving force should be justified and de-escalated as soon as possible.
Not achieved

The level of self-harm should be reduced. ACCT documentation should be completed to a high standard. Prisoners should be represented at key safer custody meetings. All serious incidents of self-harm and near misses should be thoroughly investigated and lessons learnt disseminated to staff.
Not achieved

Recommendations

Prisoners should be given comfort breaks at least every two and a half hours on journeys to and from the establishment.
Not achieved

Subject to evidence of security considerations, prisoners should be given enough notice of planned transfers to be able to inform their family.
Achieved

Reception holding cells should contain reading materials, televisions or similar activities to occupy new arrivals.
Not achieved

First night safety interviews should always be completed in private and wherever possible on the day of arrival.
Achieved

Perpetrators should be challenged and victims should be supported through concern files that contain meaningful and individualised targets.
Not achieved

A senior manager should regularly quality assure adjudication records and processes. The number of adjudications dismissed because of procedural or administrative errors or the transfer of prisoners should be reduced. Adjudicators should thoroughly explore the evidence before finding a prisoner guilty.
Not achieved

The adjudication holding rooms should be clean and free of graffiti and with a screened toilet.
Partially achieved

Planned use of force should be video recorded and body-worn cameras routinely turned on during spontaneous incidents.
Not achieved

Special accommodation should only be used in very exceptional circumstances and never for punishment.
Achieved

Prisoners on an ACCT should only be segregated in exceptional circumstances and these should be well documented. Protective measures should be put in place to support segregated prisoners in crisis.
Not achieved

Segregated prisoners confined to their own cells should receive all their daily entitlements, including mandatory visits from managers and health care staff.
Not achieved

The showers in the segregation unit should be refurbished and well maintained. Cell toilets should be clean. Segregated prisoners should have access to in-cell work and a gym.
Not achieved

There should be effective governance and oversight of the segregation unit. Good order or discipline reviews should be multidisciplinary, address prisoners' needs and assist their reintegration into the prison.
Not achieved

Security intelligence should be shared effectively to enable all departments to meet their objectives and goals.
Not achieved

Actions should be carried out promptly following the receipt of intelligence reports, including suspicion drug testing.
Not achieved

Security arrangements, including strip-searching on escorts and closed visits, should only be imposed when supported by intelligence. Restrictions should be lifted if they are no longer supported by intelligence.
Not achieved

All staff should be able to easily identify which prisoners are buddies.
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2018, prisoners were more negative about relationships with staff than at similar prisons. Staff were caring but some lacked experience and confidence. Residential areas were tidy but some needed redecoration and deep cleaning. Prisoners reported good access to telephones and showers but many emergency cell bells were not answered within five minutes. Consultation arrangements were good. Prisoners were negative about the application process and too many complaints were investigated by officers lacking appropriate authority. There were some deficiencies in the strategic management of equality and diversity work but peer representatives did some good work. Outcomes for most protected groups were reasonably good but some held negative perceptions. Faith provision was reasonably good. Health services were reasonably good but access was poor. Social care was underdeveloped and the social care needs of some prisoners may not have been met. Outcomes for prisoners were reasonably against this healthy prison test.

Key recommendation

Prisoners should be able to see health professionals easily and in a timely manner.
Not achieved

Recommendations

Relationships between staff and prisoners should be fair and courteous. All staff should be confident in challenging poor behaviour.
Partially achieved

Residential units should be deep cleaned and redecorated.
Achieved

Cells designated for single occupancy should not accommodate two prisoners.
Achieved

All prisoners should have kettles and televisions subject to disciplinary considerations.
Achieved

In-cell emergency call bells should be responded to within five minutes.
Achieved

Prisoners serving food on the wings should wear proper clothing.
Not achieved

Prisoners should receive timely responses to their applications which address the issues raised.
Not achieved

Managers should thoroughly investigate complaints about staff and interview the complainant. Complaint responses should fully answer the issues raised.
Not achieved

Prisoners' legal correspondence should only be opened in their presence, except for minimal opening to facilitate Rapiscan examination. When a letter is opened in this way, it should be marked as such to assure prisoners that the contents have not been read.
Achieved

Consultation with men in all protected groups should be effective. Managers responsible for equality work should routinely attend diversity and equality action team meetings.
Not achieved

Equality monitoring data should be analysed promptly and data of concern should be investigated without delay. The outcome of analysis and investigations should be shared with prisoners.
Not achieved

Prisoners' protected characteristics should be systematically identified on arrival.
Partially achieved

The negative perceptions of black and minority ethnic and Muslim prisoners should be investigated and addressed.
Not achieved

Professional telephone interpreting and translated materials should be used to communicate with prisoners who do not speak English.
Not achieved

Information sharing and storage should comply with professional standards and current legislation.
Achieved

Temperatures in all clinical areas should be below 25 degrees.
Achieved

The waiting area in health care should be urgently refurbished.
Achieved

There should be an overarching health promotion strategy which informs practice.
Not achieved

The health care facilities and staffing model should reflect patient need and service delivery.
Not achieved

All prisoners with social care needs should be identified, referred and assessed, and receive the required support promptly, within a robust governance framework.
Not achieved

Patients should have timely access to psychology and counselling services.
Not achieved

Transfers to hospital under the Mental Health Act should take place within Department of Health transfer target timescales.
Not achieved

Medicines should be collected from the community and stored on the wings safely and securely.
Not achieved

Patients should be able to discuss their medicines with a pharmacist.
Not achieved

Patients should receive all their medication, including in-possession medication, promptly without any gaps in treatment.
Not achieved

Stock reconciliation procedures should apply for all pharmacy stocks and medication should be stored at the appropriate temperature.
Not achieved

Pharmacy policies and procedures should be updated and governance meetings should be held regularly.
Not achieved

Waiting times for routine dental services should be comparable to those in the community.
Not achieved

Purposeful activity

Prisoners are able, and expected, to engage in activity that is likely to benefit them.

At the last inspection, in 2018 most prisoners could spend a decent amount of time out of their cells. The library was adequate. The recreational gym was reasonably good but its floor was hazardous. Managers did not provide adequate quality assurance of education, skills and work. Most strengths in education, skills and work identified at the last inspection had deteriorated into weaknesses. The number and range of education courses had reduced. The quality of teaching, learning and assessment was poor. Too many prisoners did not complete their education programmes. Ofsted judged the overall effectiveness of the provision as inadequate. Outcomes for prisoners were poor against this healthy prison test.

Key recommendation

Prison and education managers should implement robust quality improvement measures, performance management processes and a programme of staff development to raise the quality of the education, skills and work provision.
Not achieved

Recommendations

The library should organise activities to promote literacy.
Not achieved

Data on library and gym use should be analysed and acted on to ensure equitable access for all prisoners.
Not achieved

Urgent refurbishment of recreational gym facilities and equipment should be carried out, and they should be maintained in a good and safe condition.
Achieved

Prison leaders should provide sufficient and stimulating education and work activity to meet the needs of all prisoners. Prisoners should be able to obtain industry-recognised qualifications in the workplace.
Not achieved

The education provision should be staffed adequately, with appropriately qualified trainers and teachers.
Not achieved

Pay rates for prisoners should not deter prisoners from attending education.
Achieved

Prison and education managers should implement effective recording and monitoring arrangements to identify the progress and achievements of all prisoners and to improve progress rapidly when necessary.
Not achieved

Trainers and teachers should use prisoners' starting points to plan teaching and learning activities effectively. Learning and development targets should be specific and meaningful enough to help the prisoner progress.
Not achieved

Leaders, teachers and trainers should prioritise the development of prisoners' English and mathematical skills.
Not achieved

Prisoners with additional learning needs should be swiftly identified and receive the necessary support.
Not achieved

Trainers and teachers should routinely record the progress that prisoners make across all activities.
Not achieved

Prison and education managers should ensure that prisoners attend education sessions regularly.
Not achieved

Education managers should provide progression opportunities within subjects so that prisoners can achieve their full potential in subjects that interest them.
Not achieved

Prison and education managers should ensure that significantly more prisoners who start education courses complete their studies and achieve their qualifications.
Not achieved

Prison and education managers should provide opportunities for prisoners to gain suitable qualifications.
Not achieved

Rehabilitation and release planning

Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.

At the last inspection, in 2018, work to support family ties was reasonably good and improving. Visits arrangements were also reasonably good. The offender management unit worked well but links with other departments were not robust enough. Some men did not have an up-to-date offender assessment system (OASys) assessment but sentence plan targets were generally appropriate. Arrangements to protect the public were proportionate. Prisoners were positive about the good range of offending behaviour programmes. The resettlement needs of the few prisoners released to the community were generally met. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendation

Managers should formulate and implement a strategy which ensures that all departments work together to reduce risk and encourage progression.
Not achieved

Recommendations

The family links worker should be given formal specialist training and supervision.
Not achieved

Visits should start on time.
Not achieved

Managers should have a clear policy about the frequency of OASys and sentence plan reviews for different groups of prisoners and should routinely collect data to demonstrate that the policy is being met.
Achieved

Offender supervisors should have routine and effective case management supervision in high risk cases.
Partially achieved

Offender supervisors should have appropriate access to security intelligence so that they can make balanced and complete recommendations about the men in their care.
Not achieved

Prisoners should be transferred to a resettlement prison close to their release area three months before release to facilitate reintegration planning.
Not achieved

Recommendations from the scrutiny visit

The following is a list of the recommendations made in the scrutiny visit report from January and February 2021.

All prisoners should receive a full, comprehensive and prompt induction to make sure that they fully understand the regime and facilities available.
Achieved

All prisoners should have prompt access to a peer mentor in a private setting.
Not achieved

Routine GP appointments and treatment for dental patients should be provided promptly in timescales equivalent to those in the community.
Not achieved

Patients requiring assessment and treatment in mental health hospitals should transferred promptly and within the Department of Health target transfer time.
Not achieved

The library should be accessible and well promoted to encourage in-cell activity.
Not achieved

The prison should make sure that every prisoner has support to allow them to reduce their risk level and make progress against their sentence plan.
Not achieved

Ofsted
Leaders and managers need to make sure that learners with needs in English for speakers of other languages (ESOL) and those with lower levels in English are supported effectively to improve their skills.
Not achieved

Managers and tutors should make sure that learners with a learning difficulty or disability are promptly identified and suitably supported to make good progress.
Not achieved

Managers should check the quality of tutors' work rigorously to make sure that they are implementing the planned curriculum effectively.
Not achieved

Leaders should make sure that effective careers advice and guidance is available for all prisoners so that they are able to make informed choices about their careers both inside prison and upon release.
Not achieved

Leaders and managers should recognise the new skills and knowledge that learners achieve through in-cell learning and other activities, and accredit them as appropriate.
Not achieved

Appendix I About our inspections and reports

HM Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, court custody and military detention.

All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this Inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. For men's prisons the tests are:

Safety
Prisoners, particularly the most vulnerable, are held safely.

Respect
Prisoners are treated with respect for their human dignity.

Purposeful activity
Prisoners are able, and expected, to engage in activity that is likely to to benefit them.

Rehabilitation and release planning
Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release into the community.

Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by HM Prison and Probation Service (HMPPS).

Outcomes for prisoners are good.
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

Outcomes for prisoners are reasonably good.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

Outcomes for prisoners are not sufficiently good.
There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

Outcomes for prisoners are poor.
There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

Our assessments might result in identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for prisoners. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which should be attended to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Five key sources of evidence are used by inspectors: observation; prisoner and staff surveys; discussions with prisoners; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of recommendations from the previous inspection.

All inspections of prisons are conducted jointly with Ofsted or Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council (GPhC). Some are also conducted with HM Inspectorate of Probation. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

This report

This report outlines the priority and key concerns from the inspection and our judgements against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 5, 2017) (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-

expectations/). Section 7 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

Findings from the survey of prisoners and a detailed description of the survey methodology can be found on our website (see Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Martin Lomas	Deputy Chief Inspector
Sandra Fieldhouse	Team leader
Liz Calderbank	Inspector
Sumayyah Hassam	Inspector
Kellie Reeve	Inspector
Paul Rowlands	Inspector
Rebecca Stanbury	Inspector
Jonathan Tickner	Inspector
Helen Downham	Researcher
Emma King	Researcher
Samantha Rasor	Researcher
Alexander Scragg	Researcher
Maureen Jamieson	Lead health and social care inspector
Dawn Angwin	Health and social care inspector
Sue Melvin	Pharmacist
Dayni Johnson	Care Quality Commission inspector
Nikki Brady	Ofsted inspector
Karen Carr	Ofsted inspector
Diane Koppit	Ofsted inspector
Bev Ramsell	Ofsted inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Care Quality Commission (CQC)
CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: http://www.cqc.org.uk

Certified normal accommodation (CNA) and operational capacity
Baseline CNA is the sum total of all certified accommodation in an establishment except cells in segregation units, health care cells or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged cells, cells affected by building works, and cells taken out of use due to staff shortages. Operational capacity is the total number of prisoners that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

Challenge, support and intervention plan (CSIP)
Used by all adult prisons to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Not everyone who is violent is case managed on CSIP. Some prisons also use the CSIP framework to support victims of violence.

Key worker scheme
The key worker scheme operates across the closed male estate and is one element of the Offender Management in Custody (OMiC) model. All prison officers have a caseload of around six prisoners. The aim is to enable staff to develop constructive, motivational relationships with prisoners, which can support and encourage them to work towards positive rehabilitative goals.

Leader
In this report the term ‘leader’ refers to anyone with leadership or management responsibility in the prison system. We will direct our narrative at the level of leadership which has the most capacity to influence a particular outcome.

Offender management in custody (OMiC)
The Offender Management in Custody (OMiC) model, which has been rolled out in all adult prisons, entails prison officers undertaking key work sessions with prisoners (implemented during 2018–19) and case management, which established the role of the prison offender manager (POM) from 1 October 2019. On 31 March 2021, a specific OMiC model for male open prisons, which does not include key work, was rolled out.

Protected characteristics
The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

Protection of adults at risk
Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

Social care package
A level of personal care to address needs identified following a social needs assessment undertaken by the local authority (i.e. assistance with washing, bathing, toileting, activities of daily living etc, but not medical care).

Time out of cell
Time out of cell, in addition to formal 'purposeful activity', includes any time prisoners are out of their cells to associate or use communal facilities to take showers or make telephone calls.

Appendix III Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed reports distributed to the prison). For this report, these are:

Prison population profile

We request a population profile from each prison as part of the information we gather during our inspection. We have published this breakdown on our website.

Prisoner survey methodology and results

A representative survey of prisoners is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection. A document with information about the methodology and the survey, and comparator documents showing the results of the survey, are published alongside the report on our website.

Prison staff survey

Prison staff are invited to complete a staff survey. The results are published alongside the report on our website.

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